PATIENT REGISTRATION

Patient First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Sex: ___Male ___Female

Marital Status: ____ Married ____Single ___Divorced ___Separated ___Widowed

How did you hear about us: ___Internet? ___Mailing? ___ Referral?

If referred, whom can we thank for the referral?: _____

Street Address: _____

City, State, Zip: _____ Soc Sec.#: _____

Home #: _____ Cell #: _____ Work #: _____

Would you like to receive confirmations and communication via email? ____Yes ____No If YES please list email below:

Email (print clearly) : _____

Employment / Student (Circle One) Status: ___Full Time ___Part Time ___Retired

Employer/School if Student: _____

Responsible Party (if different from patient): First: _____ Last: _____

Address (only if different): _____ City: _____

State: _____ Zip: _____ Home #: _____ Cell# _____

Employer: _____ Work#: _____

Please complete bottom half if you have dental insurance

Primary Dental Insurance

Name of Insured: _____ Relationship to Insured: ____Self ____Spouse ____Child

SS/ID#: _____ Group #: _____ Insured DOB: _____

Employer: _____ Ins Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Secondary Dental Insurance

Name of Insured: _____ Relationship to Insured: ____Self ____Spouse ____Child

SS/ID#: _____ Group #: _____ Insured DOB: _____

Employer: _____ Ins Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____